Bwrdd Diogelu Plant Rhanbarthol Caerdydd a Bro Morgannwg
Cardiff and Vale of Glamorgan Regional Safeguarding Children Board

Child Practice Review C&V RSCB 01/2014

Extended Review

Co-Chairs Statement

Cardiff and Vale of Glamorgan Regional Safeguarding Children Board (C&V RSCB) accepts that this Child Practice Review report has not been completed within the 'Social Services and Well-being (Wales) Act 2014 - Working Together to Safeguard People' Guidance timeframe.

Cardiff and Vale CPR 01/2014 was initiated following a referral to the Child Practice Review Sub Group that was considered at the meeting held on the 17 January 2014. The recommendation to commission an Extended Child Practice Review was agreed by the Chair of the LSCB Main Board on 03 February 2014, with the review to be completed by 31 October 2014.

Due to a number of challenges the panel faced, the completion of this report was delayed. The Cardiff and Vale Regional Safeguarding Board have significantly improved the processes for the conduct of Child Practice Reviews to ensure that such delays in the publication of reports do not occur again. All partners who contributed to the delay in conclusion of this report have confirmed that systems now exist to ensure delays do not occur again. These regrettable delays did not stop organisations driving forward any immediate learning. This review, whilst delayed, represents important learning for all partners and the Cardiff and Vale Regional Safeguarding Board will robustly monitor the delivery of the actions and the embedding of the learning from this review.

Claire Marchant
Director Social Services,
Cardiff / Co-Chair
Cardiff & Vale Regional Safeguarding Board

Lance Carver
Director Social Services, Vale of Glamorgan / Co-Chair
Cardiff & Vale Regional Safeguarding Board

This document is available in Welsh / Mae'r ddogfen hon ar gael yn Gymraeg

Child Practice Review Report

Cardiff & Vale Regional Safeguarding Children Board

Extended Child Practice Review

Re: C&V RSCB CPR 01/2014 08.11.2011-16.12.2013

Brief outline of circumstances resulting in the Review

Legal context from Welsh Government Guidance in relation to which review is being undertaken

This extended child practice review was commissioned by Cardiff & Vale Regional Safeguarding Children Board (CVRSCB; formerly known as CVLSCB, Local Safeguarding Children Board) in accordance with Protecting Children in Wales Guidance for Arrangements for Multi-Agency Child Practice Reviews (Welsh Government **2013**). The criteria for this review are met under section **6.1** of the above stated Guidance:

6.1 A Board must undertake an extended child practice review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has:

- Died; or
- Sustained potentially life threatening injury; or
- Sustained serious and permanent impairment of health or development

and

The child was on the child protection register and/ or was a looked after child (including a care leaver under the age of 18) on any date during the six months preceding:

- The date of the event referred to the above; or
- The date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

The Terms of Reference for this review are at **Appendix 1** (which also incorporates the reasons for delays in respect of this CPR process).

Circumstances resulting in this review:

This Extended Child Practice Review (ECPR) considers the circumstances of two siblings who, at the time of commencement of this review were and remain subject of a Care Order to the Local Authority. Since September **2013** they have been accommodated in a residential therapeutic placement in

England, where they continue to reside. An ECPR was commissioned following a recommendation from the Child Practice Review Subgroup of the Cardiff & Vale RSCB on **13th November, 2013.**

The timeline of this ECPR focuses on the multi-agency professional intervention to safeguard these children between the **8th November 2011 to 16th December 2013.**

During the period of the timeline the eldest child was aged between 9 and 11 years and the younger child was aged between 7 and 9 years.

Throughout their lifetime the children subject of this review and their family were known to a number of support services and agencies across Cardiff and the Vale of Glamorgan. It is apparent that concerns were identified relating to neglect, physical, emotional and sexual abuse which were shared and reported by agencies. Services were involved over a ten-year period with Child Protection (CP) Procedures being instigated. There were 6 periods of CP registration between **2002** (pre-birth conference re the oldest child) and **Dec 2013** when a decision was made in response to Mother's request to accommodate both children. The categories of registration included neglect, physical and emotional abuse, either singly or in varying combinations.

It must also be acknowledged that the children's Mother had an extensive history of involvement with statutory services and other support providers in respect of her five older children and information pertaining to this pre-timeline period will also be considered where it is deemed relevant to the experiences of the two youngest children subject to this review.

Contextual information outside of the timeline.

Some significant contextual information outside of the review timeframe was received both from agency records and through discussion with family and professionals involved. Mother's first significant relationship commenced when she was 16 years of age with her first child being born when she was 17. Over the next 11 years, four more children were born to her. During this time, it is acknowledged that the children's mother had an extensive history of involvement with the Local Authority. As a consequence of her reported violent relationship her five children were made the subject of care orders and placed outside of the birth family. The concerns at that time included, significant neglect.

Mother subsequently left this relationship and engaged in another, which resulted in the births of the two siblings subject to this review. This relationship was similarly characterised by acrimony and volatility and ended with mother leaving the children's father and taking them to live with a new partner. This third significant relationship of Mother's was similarly violent and abusive and it is during the period of this relationship that the events which are the focus of this timeline occurred.

A pattern of behaviour emerged of Mother as a vulnerable individual who led a chaotic and unstable lifestyle which has had a detrimental impact on these

two children. She had repeatedly been involved with violent partners and had frequently moved home and commenced new family configurations, ostensibly as a new start each time but in reality with very little having changed. When offered help and support, she would often reject this, minimising the impact of the violence and abuse experienced by herself and by her young children. When advice was sought and provided, she invariably failed to follow through on appointments, support and strategies offered. Thus, these two children witnessed incidents of domestic violence and were subjected to neglect, physical, sexual and emotional harm over a sustained period of ten years with some of the concerns mirroring those which had led to the removal and accommodation of Mother's previous five children.

Significant Events During the Period Under Review

At the commencement of the timeline period, the two children were living with their mother and her partner. They had sporadic contact with their biological father–supervised by Paternal Grandfather. Other family contacts were with Maternal Grandfather, older Maternal step siblings and with cousins. An adult son of Mother's current partner also featured in the children's lives as a visitor to the family home.

Following a period of Child Protection Registration, it was the unanimous decision of the quorate Review Child Protection conference on **8th November 2011** that the names of both children were removed from the Child Protection Register and that they received continued support under Child in Need arrangements for a further five months.

Prior to the subsequent Local Authority case closure in **April 2012**, key agencies involved continued to record concerns with respect to the children's behaviour, their extremely low levels of literacy and numeracy, their difficulties in cognitive functioning and in socialising with peers, inappropriate hugging and kissing with children and adults, their poor physical health and development and their emotional wellbeing; Mother's capacity to nurture and protect the children was also considered in this context. Such concerns were shared, but not always consistently via the required reporting mechanisms.

In **May 2012**, reports began to be received by Children's Services regarding Domestic Violence in the household, perpetrated by Mother's partner. The children were known to have been present during such episodes and reported hearing their mother cry and seeing bruises on her.

Health professionals recorded concerns about both children's poor growth and nutrition. Mother provided inconsistent explanations to professionals: In a Dietetic appointment on **04.09.12**, the youngest child was recorded as being underweight. Mother reported that the child had a good appetite but was a slow eater, but at a joint Paediatric and Child and Adolescent Mental Health Service (CAMHS) appointment on **07.09.12**, she reported that the child refused meals and was only taking 1 prescribed high calorie supplement per day. The differing information provided by Mother in appointments three days apart does not appear to have been fully

considered and followed through, apart from encouragement to Mother to send the supplements to school and planned follow up there to ensure this.

In **November 2012**, Mother and both children entered a Women's Aid Refuge staying 3 nights but left before assessments could be completed. Staff were concerned re the oldest child telling of how they had tried to set fire to a previous home as the neighbours downstairs were annoying them and that their dad "talked about sex" when he had contact with the children. The youngest child said they wanted to kill themselves when Mum and partner argued and that their older sibling had attacked their Mum with knives and punched her in the stomach. Both children reported hearing threats made to their Mother by her partner that he would kill her, on one occasion with a gun and on another with a drill.

Contemporaneous to this, the children's school reported both children as functioning well below average in literacy and numeracy and that the youngest often made noises and twitched. Both children disclosed concerns about their Mother being upset and hearing her cry. School were also increasingly concerned re the eldest child's use of inappropriate sexual language and sexualised behaviour.

In **Jan 2013**, when Mother and children were in Refuge for a second time, a Core Assessment was completed with the outcome that the children continued to be worked with as Children In Need, but that concerns would escalate if the family left the refuge. On **30.01.13**, Mother left the refuge with both children, with concerns shared by Refuge staff re what the children were witnessing and hearing, with the youngest now wetting the bed.

It was at this time that the nature of concerns began to centre on disclosures of sexual abuse, due to words spoken and behaviours exhibited by both children.

On **07.02.13,** a Strategy Meeting was convened between Cardiff Children's Services and South Wales Police and a Section 47 Child Protection investigation agreed.

On **18.02.13** School recorded that the youngest child threatened to stab another pupil with a fork and on **25.02.13** was upset in class crying about their nan, whom it later transpired they had never met.

It was the unanimous decision of the quorate case conference held on **28.02.13** that both children's names be placed on the Child Protection Register under the categories of neglect, physical and emotional abuse. Registration under the sexual abuse category was considered, but not pursued.

In **March 2013** concerns had escalated further as the Community Paediatrician who saw both children at an outpatients appointment reported that the youngest child had faltering growth and further weight loss, constipation and ADHD and the older child had similarly faltering growth due to lack of feeding, neglect and poor sleep, hygiene and constipation. Neither

child was having the high calorie supplement drinks with Mother saying she had run out of them four weeks earlier. Concerns were communicated in a letter to the children's Social Worker but not as a Child Protection Referral on a Multi-Agency Referral Form (MARF).

Concerns relating to sexual abuse continued to be shared and discussed between agencies involved. Some of these were instigated by Mother accusing the children's biological father, but school also shared numerous concerns with respect to the significant sexualised behaviour exhibited by both children. On **28.03.13** at the request of the mother the children were accommodated under Section 20 of the Children Act 1989 after she confirmed that she could no longer manage their behaviour. The children were placed together with Foster Carers.

During this placement, the disclosures of sexual abuse and concerns regarding the children's behaviour increased significantly. These included reports that both Father and Mother's current partner had talked of and /or tried to engage both children in sexual acts and encouraged them to remove their clothes and engage in sexual acts with each other. Contact between both adult males and the children was suspended whilst investigations were carried out by Children's Services and South Wales Police. Following a Strategy meeting on **30.06.13** Care Proceedings were instigated and both children were referred to the Sexual Assault Referral Centre (SARC).

Further and increasingly concerning disclosures were made by both children of unwanted and extreme sexual thoughts and desires which made them very uncomfortable. Medical examinations were undertaken in **July 2013** with respect to these concerns and whilst the findings did not exclude sexual abuse, they were inconclusive. Thus, it was considered that there was insufficient evidence to progress criminal proceedings and the concerns of sexual harm therefore remained within the context of the children's disclosures. The Family Proceedings Court granted an Interim Care Order on **12.08.13** and at a hearing on **30.08.13** the Court sanctioned a therapeutic residential placement for both children. On **02.09.13** they were placed within that setting where they have continued to live to the date of completion of this report **(November 2017)**

Practice and organisational learning

The purpose of a Child Practice Review is to identify learning for future practice, and involves practitioners, managers and senior officers in exploring the detail and context of the work undertaken by agencies with a child/ren and their family. The output of a review is intended to generate professional and organisational learning and promote improvement in future inter-agency child protection practice, with a focus on accountability and not on culpability (Protecting Children in Wales Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government 2013).

It is acknowledged that the Learning Event convened as part of this CPR took place sometime after the CPR was originally commissioned. However, agencies fully participated in the process. The Learning Event was attended

by professionals who were directly involved with the family during the period of the timeline. During the review period and at the Learning Event despite the delay a number of themes emerged with some key learning points and effective practice identified as follows:

THE IMPORTANCE OF THE VOICE OF THE CHILD:

Throughout the specified timeline period it was noted at the Learning Event that the voice of the child was not always easily identifiable and there were potential missed opportunities when consideration could have been given for the children to be spoken with and listened to. These included the occasions when Child Protection referrals were received with the outcome of no further action (NFA), however there was no evidence of the views of either child being sought on any of these occasions by referring agencies or Cardiff Childrens Services. These referrals were often made due to information disclosed directly by both children individually to school staff, refuge staff and foster carers. Good practice informs us that children are most likely to disclose abuse in environments where they feel safe and engage with professionals without the presence of parents and carers. The attendees at the Learning Event were of the opinion that these two children at times disclosed abuse within this context but did not see any effective actions being taken by professionals and, as a consequence, the children's perception of non-response and inaction to their disclosures is extremely likely to have contributed significantly to the long lasting damage caused to the children's emotional health and wellbeing.

Questions were also raised with respect to the individuality of each child and whether this was recognised and appropriately responded to in a consistent way. Whilst acknowledging the challenges of presenting anonymised reports which consistently distinguish individuality, in agency records where the children were not required to be anonymised they are often referred to as one unit, with little or no recognition of their individuality, differing personalities and specific needs; they are repeatedly represented as one set of issues and concerns. In addition to the obvious apprehensions arising regarding the impact of not treating each child as an individual, it was felt by participants at the Learning Event that such an approach risked not giving due consideration of the possibility of the need to safeguard the children from each other.

The impact on the sense of identity of each child was also felt to have been harmed by the abusive name calling they reported as receiving from Mother's partner. Both children shared their fears and anxieties about Mother's partner on several occasions; records from multi agency meetings document that each had expressed that they were frightened of this man and that he had threatened them with going into care if they didn't behave, but there was little evidence that services had taken the appropriate action to reassure the children or reduce their anxieties. When they were in foster care they feared that he "would get them" and that he "would kill their animals". They also feared for their Mother's safety; their home was in close proximity to their school and they could often be found standing near a fence from which their house was visible, hoping to see her and that she was ok.

In addition to the neglect and abuse experienced by these children, the level of responsibility that they assumed for their Mother's wellbeing was akin to being young carers and as such they missed out on many childhood experiences that other children take for granted. They had difficulties forming friendships with their peers, especially the older child, who was said to be jealous of any success that their younger sibling had in forming friendships and exhibited this in their behaviour. They were increasingly isolated from family as Mother's sister, who had been a relative who featured regularly and positively in their lives, had stopped visiting due to her negative feelings about Mother's relationship with her partner. Contact with Father had also diminished and despite the acknowledged reasons for this, neither child seemed to recognise the risks or the reasons for such decisions being made nor receive support to do so. Therefore, both children continued to speak positively about their relationship with their Father and of their desire to see more of him.

The children were isolated and their access to people who would listen and advocate diminished. When they were seen by professionals, they often related information exactly as they experienced it, as when saying Mother's partner was unkind and telling of incidents where they or she were threatened or hurt. It is acknowledged that the both children were young but this was not sufficient reason to decide that their views were not sought or acknowledged in the decision-making processes which affected them. The challenges of communication with young children are not denied and commendable efforts were made by the police in their attempts to interview both children in **2013** regarding the alleged sexual abuse they had suffered but generally the overwhelming feeling from examination of the timeline was the absence of their voice and views and an over reliance on the opinion of adults. At the point where decisions were made regarding case closure in **April 2012**, the children were exhibiting concerning behaviour in school and at health appointments including the youngest making noises and twitching and inappropriately kissing and hugging other children in school. Some professionals at the learning event questioned the decision to close the case when the children were clearly still showing concerning behaviour.

Recommendations:

- **Children must be treated as individuals regardless of any shared environments and/or caregivers. Their needs should be assessed and views considered separately. Consideration also should be given to their behaviour, impact on each other and possible risks posed to each other.**

- **In addition to listening to a child's expressed wishes and feelings, professionals should give equal consideration to a child's behaviour and presentation and seek to understand this non-verbal communication.**

- **C&V RSCB should ensure access to multi agency training on the voice of the child with a focus on effective**

communication methods with younger children.

PARENTING CAPACITY:

This is inextricably linked to the previous point regarding listening to the children. The panel members and attendees at the Learning Event all agreed that too much trust was repeatedly attached to what the Mother said and questioned why her view was often so easily accepted. A common theme emerged that Mother could and should have done more to protect her two young children but instead she repeatedly failed to see the emotional impact on them when observing her with bruises and crying due to the domestic violence she suffered. When the Reviewer and Chair met with Mum, she continued to minimise saying the children never saw any violence as when it occurred they were in their bedrooms or at school. On a visit she made to them when they were accommodated, she did not recognise their distress at seeing her without teeth and covered in bruises. In addition, their anxiety and upset was further exacerbated shortly after this contact when they received news that their Mother had married the alleged perpetrator. This echoed an earlier pattern where she moved in with the same man four weeks after the children's names were removed from the CP register. In the context of the violent relationship in which she was engaged with a volatile and controlling partner, there were unrealistic expectations placed on the Mother to separate herself from him in order to protect her children.

At the Learning Event issues were identified regarding Mother's emotional intelligence and ability to empathise as well as with respect to possible disguised compliance or the inability to comply. This was particularly pertinent when she reported concerns regarding the children's father. Whilst she was purporting to be prioritising the safety and wellbeing of her two young children, she was at that time engaged in a custody battle and thus could have been deflecting scrutiny from herself onto her ex-husband. The custody situation and acrimonious relationship was also used by the Mother when she was contacted by Children's Services re receipt of an anonymous referral reporting arguments at the family home involving her and her partner who was said to be under the influence of alcohol. Her view was that these reports were of a malicious nature and instigated by her ex.

Professionals' efforts were focused on maintaining the children at home and reducing risks by ensuring that mother and partner engaged with services and attended support programmes. Thus, Mother reported to be attending a Parenting Programme for families of children with Attention Deficit Hyperactivity Disorder (ADHD) in **February 2012**, completing a Connors Questionnaire in **April 2012** and in **March 2013** it was recommended that that Mother attend the Freedom Programme and that her partner attend the Caring Dad's Programme. Reference is also made to Mother having successfully completed a Parent Nurture Programme, attending 9 of 10 sessions and engaging actively in these and of the possibility of Incredible Years as a further positive parenting intervention. The Neglect Toolkit is repeatedly mentioned with evidence of completion on two previous occasions. There is no evidence that all of these recommendations identified were followed through and where they were, the only recorded change in the

behaviour of Mother is in respect of household and practical tasks being addressed. Thus, bedrooms are redecorated and each child appears cleaner and tidier at school. There is no evidence of any increase in Mother's awareness of the reasons for professionals' concerns and the children's troubled behaviour continued. Despite the support provided, Mother appeared to demonstrate a continued lack of understanding that both her children's individual needs had to be met on a consistent basis.

The fact that the home environment improved slightly seemed to shift the focus from the children's real experiences which continued to be that they lived in a stressful environment which impacted on their emotional health and wellbeing. None of the courses seemed to have enabled Mother to be aware of the impact that her behaviour had on her children. She spoke openly to them about the volatile nature of her relationship with their biological father and they witnessed the violence that she suffered with her current partner. However, engaged she was with programmes, the lessons that she needed to learn for the benefit of her two young children were missed.

Examination of the timeline did not reveal evidence of any assessment of Parenting Capacity having been undertaken in respect of Mother. During the visit made to Mother by the Reviewers, questions as to her level of understanding were identified. This was noted in respect of the Review Process and the events which had led to this as well as her understanding of the impact of her own history and childhood experiences. Agency records were examined to help provide a more detailed picture of Mother, past and present. These revealed that she was registered disabled and was in receipt of the higher rate of Disability Living Allowance. She told professionals that she suffered with complex health needs. Her mobility and motivational levels were thought to be adversely affected as a result. References are made in reports to her having a learning disability, although it is not clear if any formal assessment took place. A report from a Clinical Psychologist during the Care Proceedings in respect of children from an earlier relationship describes her as "intellectually limited, emotionally immature and demonstrating major difficulties in maintaining and organising basic family functions". This was a vulnerable parent who lacked the capacity to parent these two children adequately. This information should have been considered by all practitioners, including social workers, in subsequent interactions with the mother and practice adapted accordingly. Unrealistic expectations placed on mother by Children's Services should have been challenged. The assessment should have included: Mother's previous experience as a parent and the outcomes for her older children together with an assessment of her current parenting capacity and her functioning ability. Mother also said that she had suffered abuse as a child including sexual abuse. Similar questions were raised regarding the past history of Mother's partner. It transpired that he was known to police in relation to four incidents of Domestic Violence with a previous partner with alcohol being a theme in most of these.

Recommendations:

- **C&V SCB should ensure training is provided to equip**

professionals to be able to recognise when a parent has additional needs which mean they require more support to understand the concerns of professionals and what is being asked of them and how to adapt practice accordingly, for example through the use of PAMs assessments.

- **Professionals must be cautious of placing expectations on vulnerable parents to understand concerns and make the necessary changes within a child's timeframe and must be clear when they do not have the capacity to do so.**

COMPLETION OF TIMELINES & CONTEXT OF HISTORIC EVENTS:

During the review process and at the Learning Event panel members and practitioners raised queries with respect to gaps in information and knowledge. Whilst the Reviewers have been able to follow up in some cases and obtain additional information, this has not been consistently possible. In particular, practitioners at the Learning Event felt that availability of information with respect to Mother's background and family history in particular relating to her older children from a previous relationship was lacking.

Whilst it is acknowledged that this review focused on a different time period and a different family configuration, information received by the Reviewers following the Learning Event regarding Mother's past history resonated strongly with the experiences of the two little children in this case. There are striking similarities between their lives and those of their older half siblings and in relation to Mother's ability to prioritise and meet the needs of her dependent children during both periods of parenthood. Given the fact that mother received significant levels of support over many years, the expectation would be that if she were to make any significant changes these would have happened by now.

Consideration was given to the counter argument of the significance of past events on the current situation and whether information would have been used to prejudge and promote a "set up to fail" environment, but the unanimous view of all involved was that whilst the focus of the two year timeline and the period defined therein was understood, it was essential to ensure the protection and wellbeing of these two young children that a holistic picture was obtained and that incidents in their lives were not treated as isolated events but viewed within the historic context.

This information was viewed as key during the review process not to shift focus from the two year time line or to the detriment of the CPR process, nor to apportion blame to decision making regarding past events, but because of a fundamental belief that in attempting to address the parenting behaviour that was being witnessed with this Mother, it was important to have an understanding and awareness of her past childhood experiences and how they related to her parenting knowledge and behaviour. It was not that it was felt that past behaviour was inevitably repeated and be used as an indication of failure, but that knowledge of the past needed to be combined with with examinations of the behaviours being witnessed in the present as an aid in

clarifying the strategies Mother used in parenting her children and to enable professional support providers to deliver targeted help which would effect change.

- **When working with families, professionals must take into account family history. Assessments should include any previous experience as a parent and outcomes for any other children, together with an assessment of current parenting capacity and functioning ability.**

- **Decisions must be made within a child's timeframe.**

INTER AGENCY COMMUNICATION & INFORMATION SHARING:

It is acknowledged and accepted that in order to ensure good practice in safeguarding and protecting children it is essential that timely and effective communication mechanism are in place that support services and individuals in sharing information between agencies.

This Review highlighted some good examples of this such as the school sharing information with respect to the children's education and both Education and Health services sharing concerns regarding the children's wellbeing and the dynamic between the siblings and their relationship with Mum and her partner. There were some acknowledged delays and on occasions a lack of clarity regarding what had been referred and followed up and what had just been noted in agency records. When concerns were shared with Children's Services, the response or absence of response was not always the outcome expected by referrers, leading to a frustration at what was felt to be the absence of a timely co-ordinated multi-agency approach in addressing these concerns and increasing dissatisfaction at what were perceived as missed opportunities to intervene and protect these children.

There was some discussion with respect to the Data Protection Act (DPA) and this being perceived as a reason why information is sometimes withheld but whilst it was acknowledged that with respect to certain information a sound rationale for sharing was necessary, the overriding importance of protecting children was viewed as paramount and therefore DPA concerns were not accepted as an explanation of poor communication and lack of information sharing in this case. Practitioners expressed concern that if information was not shared effectively, those involved in supporting a family would not be able to gain a holistic view of their lives. It was emphasised that records needed to follow children and families as they moved between agencies as these two children did when changing schools and paediatric services. It was not clear to agencies whether the two differing stories with respect to the children's diets were checked out fully (on **04.09.12** and **09.09.12**) other than between the Dietician and Paediatrician. A similar lack of clarity was noted with respect to inter agency communication between Health & Children's Services on **04.03.13** where a letter outlining significant concerns was sent to the children's Social Worker

but not submitted as a child protection concern on an appropriate multi agency referral form (MARF). The process outlined in the All Wales Child Protection Procedures for Wales is that 'preferably' information should be submitted on a MARF, but this is not a mandatory requirement.

At the Learning Event, the representatives of the school that both children were attending at the time raised significant concerns regarding their lack of awareness of written agreements which stipulated that the children were not to be left alone together or with other children. As a consequence the children were not supervised as stipulated within the school setting. All agencies agreed that such significant information should have been shared with all involved in order that appropriate, consistent and timely actions could be taken.

Multi-agency meetings were seen as providing golden opportunities for effective information sharing and as such it is vitally important that key agencies working with families are invited to these. Examination of the timeline raised queries with respect to who was present or represented by reports at key meetings. Further examination of meeting records by the reviewers revealed that generally meetings did operate on a multi-agency basis and were inclusive of key agencies working with the family at the given time, but this was not consistent as with the Children In Need Review Meeting held on **20.02.12**, where only the parents and Social Worker were present. It is noted that Health and Education were invited but did not attend, with Education saying this meeting fell on an in-service training INSET day. There is no record of any information or report being submitted by nor sought from either agency, although the timeline evidences that a report was submitted by Education on **13.03.12**, a three-week delay and too late to influence decision making at the CIN meeting. At this meeting decisions were made to end the support from the Family Intervention and Support Service (FISS) and reduce statutory Social Work visits from four to six weekly.

Recommendations:

- **C&V RSCB should ensure all staff are trained to understand that where there a concerns for the safeguarding of children under the age of 18 years, they must share information with colleagues in other agencies, in particular with Police and Children's Services.**

- **C&V RSCB should ensure that all agencies are clear that any Child Protection concerns must be submitted on a Multi-Agency Referral Form (MARF) and within the timescales set out in the All Wales Child Protection Procedures**

- **Police Protection Notices (PPNs) from South Wales Police should be sent to schools in Cardiff as practiced in the Vale of Glamorgan.**

- **All professionals involved should attend Care and Support Planning Meetings and send a representative if they cannot attend.**

PROFESSIONAL CHALLENGE:

The issue of professional challenge became a recurring theme throughout the review process. At the core of this was the relationship between Children's Services and other agencies which was frequently misunderstood.

With regard to statutory services leadership of Child Protection processes, discussions revealed a tension between agencies being happy to have Children's Services leadership and expertise at the helm, but questioning this authority when decisions were felt to be autonomously made. Frustration at the lack of response to concerns shared was repeatedly expressed at the Learning Event, but this was invariably not followed up by professional challenge. Many agencies shared that staff lacked confidence in challenging decisions and whilst they expressed a desire to improve the situation and encourage open and honest conversations and respectful challenge, they did not know how to commence this. Knowledge of the Professional Challenge Protocol was sparse amongst participants at the Learning Event.

Recommendations:

- **C&V RSCB to promote the Resolution of Professional Differences Protocol across all agencies. This document should be referenced at Multi Agency Meetings Case Conferences and related meetings and used effectively to facilitate an environment in which it is safe to raise legitimate professional challenge.**

SEXUAL ABUSE:

Much discussion and reflection took place amongst professionals at the Learning Event regarding the category and why it was not used in any of the CP registrations. Participants felt that the repeated disclosures made and concerning behaviours exhibited by both children were not then sufficiently reflected in the registration categories. Also, sexual abuse was thought to rarely happen in isolation from other forms of abuse which the children were known to be victims of, so greater consideration should have been given to registration under this category.

The impact of medical examinations and police investigations on people's understanding of sexual abuse was discussed. With respect to the former, examinations were carried out on the children at the Sexual Assault Referral Centre (SARC). During the examinations the elder child was initially reticent to say anything but then talked of their Father "doing the S word- S.E.X" (spelled out) with them and their younger brother similarly

disclosed episodes of sexual abuse to which they had been subjected. Contact with Father was stopped in line with the expressed wishes of the children, but clinical conclusions were that the concerns of sexual harm remained in the context of the children's disclosures. Therefore whilst medical examinations did not exclude sexual abuse, they were inconclusive.

Police investigations were commenced but with a similar outcome. The children made various and numerous disclosures whilst in the foster care setting which were all followed up appropriately by the carers and their agency, but criminal proceedings couldn't be progressed because the children did not disclose to the police. At the Learning Event police colleagues related the efforts made in order to try to gain evidence from the children, but to no avail. The police endeavours were viewed as evidence of good practice in relation to this case. It was felt likely that the children had developed a lack of trust in authority figures, associating the police in particular with negative aspects of their lives characterised by violence.

Other issues impacted on the ability of the police to build a case, including inconsistencies in the children's accounts and the role of mother in influencing them whilst engaged in a custody battle with their father. The fact that sexualised behaviour is not necessarily a sign of abuse but could be exploratory or a sign of trauma, neglect or other abuse was also explored with many professionals stating that they lacked awareness of how to talk with children where they noticed sexualised behaviour; whilst acknowledging the need to address, they simply did not know how to have these conversations.

The difficulties of criminal prosecutions and the need to prove that an offence has taken place beyond all reasonable doubt were discussed at length. Participants at the Learning Event felt that there possibly was a general lack of understanding amongst other professionals who might misinterpret failure to secure a criminal conviction as a conclusion that sexual abuse had not taken place. This culture of focusing on successful criminal prosecution and conclusive medical evidence as required proof that an incident took place needs to be challenged. The time taken for any prosecution process can be time lost in which children may be ready to start therapeutic work.

Questions were raised with respect to the thoroughness of investigations of the sexualised behaviour exhibited and the children's disclosures when they were not registered under the sexual abuse category. Whilst, as with medical and police evidence, registration should not be viewed as required proof of abuse taking place, it was thought that use of the category in this case would have kept professionals alert to the risks of significant harm of any nature, whereas what was felt to have happened was that not using the category together with the emphasis placed on medical and police evidence contributed to the focus being shifted from this area of concern. This was felt to not only leave the children at greater risk from any possible adult perpetrators, but also left them at risk from each other and to other children.

Recommendations:

- **Greater understanding is needed with respect to the place of medical evidence and criminal proceedings in cases of alleged sexual abuse to ensure that a direct and damaging correlation is not made between inconclusive findings and outcomes and proof of abuse.**

- **Significant and substantial recognition should be given to a child's presentation and behaviour irrespective of medical evidence and criminal proceedings.**

- **Children who make disclosures should be made aware by police and others that the lack of a conviction does not mean that they are not believed by professionals.**

- **C&V RSCB should ensure access to multi agency training regarding effective ways to communicate with children where sexual abuse is suspected.**

- **C&V RSCB to ensure promotion of the Sexually Harmful behaviour Protocol across all agencies and promote its use in relevant cases**

ADHD:

Throughout the timeline period reference is made to the possibility of both children having ADHD. This view was initially expressed by Mother at a Paediatric appointment on **24.11.11** and at a Child In Need Meeting on **20.12.11** where she said that she would be commencing attendance at an ADHD course at St. David's Hospital. Mother repeatedly expressed a desire to find out more about ADHD so that she could better manage the children's behaviour; thus she was not seeing any connection between their behaviour and the environment in which they were living and the violence and abuse to which they were exposed and experiencing. She clearly saw her difficulties in managing the children's behaviour as attributable to their ADHD.

A diagnosis of ADHD was questioned by a Paediatrician on **23.02.12** with respect to the younger child as they were "not displaying typical signs" but was later confirmed with respect to this child at a joint Paediatric and CAMHS appointment on **25.05.12** and medication prescribed. School noted little change in their behaviour following this. At the CP Conference on **06.03.2013**, it was noted in the Chair's report that "both children were diagnosed with ADHD and have special needs in this respect and both receive significant support in school".

The concerns arising from the Learning Event were that there was a focus on ADHD to the detriment of other concerns and that once diagnosis was confirmed and medication prescribed, further concerns of professionals were not fully investigated as they were attributed to

behaviours associated with ADHD. During the early part of the review in particular there were repeated references to behaviour which may have been attributable to ADHD, but this should in no way have resulted in other considerations and investigations being halted. This is not to minimise the importance of the medical diagnosis being obtained, but that this needs to be viewed within the context of the environment in which the children were living, their presentation in the school setting and other concerns being shared together with repeated historic behaviour patterns on the part of Mother.

Recommendations:

- **Professionals need to be alert to the possibility that a focus on a medical diagnosis as the explanation for behaviour exhibited by a child presents significant risks of the diagnosis being interpreted as the root cause of all subsequent concerning behaviour displayed by the child.**

DNAs:

The use of the term "DNA" with respect to children was discussed with unanimous agreement that DNA should not be used in such cases as the children were not able to affect attendance in any way. In reality the children were "not brought" to appointments by their adult carers and it was felt that this is the phrase that needed to be used to more accurately describe such incidences.

The review timeline and agency records evidenced numerous occasions where the children were not brought to appointments, with a variety of reasons given including adverse weather, lack of public transport or not being able to contact services to rearrange inconvenient dates. Whatever the reasons, it was strongly concluded and that children should not be discharged from a service after 2 missed appointments. Failure to attend was in no way their fault and yet current practice punishes them for the shortcomings of adults.

Participants left the Learning Event determined to investigate this practice and to actively seek change. Health colleagues felt particularly strongly regarding information sharing with respect to missed appointments as it was thought that if the Dietetic Service discharging the children in line with current practice had been fully aware of their history and circumstances, a referral to Children's Services would and should have been made.

Recommendations:

- **The term DNA to be replaced with the more accurate "was not brought" in respect of appointments for children. Non-attendance at an appointment should not result in automatic discharge but should be communicated to relevant professionals involved.**

REFERRAL, REPORTING & MONITORING PROCESSES: At the learning event it transpired that there was a lack of clarity with respect to exactly what constituted a referral. Concerns were raised that a letter sent from the Community Paediatrician to Children's Services on **04.03.13** should have been submitted as a CP referral on a Multi-Agency Referral Form (MARF) rather than a letter as this could have minimised the seriousness of the concerns being shared.

Several issues arose which exhibited a lack of awareness and consistent understanding amongst professionals with regard to the systems and processes required when sharing safeguarding concerns, making Child Protection referrals, obtaining feedback re referrals made and in generally fully comprehending different professional roles and responsibilities.

Several agencies reported the lack of follow up when referrals were made to Children's Services, but added that they were unaware of or did not consistently utilise the process to follow up. Wales Ambulance Service stated that they had no awareness of the outcome of referrals made and if they did become aware of an NFA outcome, would not be aware of the process by which they could gain further clarification of the decision-making process. It was noted that the AWCPP (2008) states that referrers should seek feedback regarding referral made if this has not been received within 10 working days of the referral being made.

Recommendations:

- **All agencies need to have a clear understanding of the processes to be followed when sharing safeguarding and CP concerns as laid out within the AWCPP and referrers and recipients to understand and accept communication as a two-way process, taking responsibility with respect to timely responses and actions.**

- **Multi Agency Training should be provided with regard to referral, reporting and monitoring processes.**

CASE CONFERENCES & CHILD IN NEED MEETINGS:

Many queries were raised with respect to attendance at Case Conferences. When examining the time line, professionals sought clarity with regard to who had been present at meetings where decisions regarding registration and de-registration were made to help in understanding the decision making processes in light of their being unanimous or whether opportunities for professional challenge were afforded within the process and if so whether these were utilised.

Similar queries were raised with respect to the CIN status and whether meetings were held and plans formulated and if so, were key agencies involved in supporting the family integrated into these in order that all

agencies could contribute in a co-ordinated way. The timeline entries did not evidence this and the lack of such an approach was felt to contribute to the prevention of a whole picture being obtained and that some services working with the family then made decisions in isolation. Particular reference was made re the decisions to close Family Intervention Support Service on **20.02.12** and to close the case to Children's Services on **24.02.12.**

Recommendations:

- **For children subject to Child in Need Plans, C&V RSCB should ensure that there are multi agency processes in place to ensure engagement in meetings and plans from all involved with a family; such multi agency contribution is particularly important when decisions re any reduction in support or case closure are being made so that the implications can be fully considered**

- **Where agencies are unable to attend meetings or reviews, they should send a representative.**

REGISTRATION / DE-REGISTRATION:

When considering registration and de-registration processes, practitioners at the Learning Event raised issues around decision making processes and whether the outcomes were generally accepted or ever challenged. The two periods of registration posed queries with respect to whether legal proceedings should have been considered at an earlier stage.

There were further discussions regarding the support provided for children and families when de-registration occurs and whether this was sufficient. It was noted that there is potential for parents to do what is expected of them in order to get children's names removed from the register only to revert to type once this has been secured.

Recommendations:

- **Clarity is needed with respect to trigger points for legal proceedings to be instigated, particularly where de-registration and re-registration occurs repeatedly.**

- **De-registration must be better understood by all professionals as the removal of a name from the CP Register, but not that the support needs of the children involved have all been met nor that there is no longer need for a co-ordinated professional support network. Care and Support processes need to be robustly co-ordinated and supported by all agencies involved.**

WRITTEN AGREEMENTS:

Reference is made to the use of written agreements with Mother and the

use of these in this particular case was discussed by practitioners at the Learning Event. The general consensus of opinion was that these documents, at best, had little meaning and were unhelpful, placing an unrealistic expectation on the Mother and that at worst they risked being perceived as a safety measure. Whilst they might provide a degree of reassurance to the agency, they did not serve to protect the children.

It was agreed that there could be a place for an agreement which helped put local authority concerns into perspective for parents and that when parents contributed to and understood an agreement, it could lead to positive outcomes for the children. They could be a useful way of communicating concerns with parents and were useful in gathering evidence on parents' ability to change and work with services. However, this was not felt to be the case with this family and as such the use of written agreements was thought to be an unhelpful and ineffective.

Recommendations:

> **Consideration around the use of written agreements as evidenced in this case to be replaced by more open, transparent and supportive approaches which engage and involve the family throughout.**

CONTACT WITH FAMILY:

One of the Reviewers accompanied by the Panel Chair met with Mother at her home on **06.09.17**. Prior telephone contact had been made with Mother to arrange this visit and these conversations were difficult with Mother providing monosyllabic responses which seemed indicative of her lack of desire to meet or her negativity about the review process. Upon meeting her, however, it very quickly became apparent that she had not fully understood the reasons for the visit or the review. She said that she did not know why she was being contacted. She had received a letter from the Panel Chair, but said that she hadn't understood what this was about. In fact, she had thought our visit was to communicate updated information about the children-possibly regarding their return as she thought the eldest was due to move back soon.

The review process was outlined to Mother and it was made clear that her views were being sought as an important part of this. Mother was asked about the support that she had received when the children lived with her and whether she thought anything could have been done in another way which would have effected a different outcome. Mother found it difficult to be reflective about the past, especially with respect to events leading to the children being accommodated. Mother did not seem to fully comprehend her part played in this by her putting her own needs and her relationship with her partner before her children, except in that she cited her partner as the reason her children were taken away and that she only had contact with them six times a year.

Mother described a life time of abuse, from childhood and through her adult

relationships. She said that her last relationship had resulted in her losing her children and contact with her family. She said she had been close to her sister but this had drifted as she did not like Mother's partner. She said that she now recognised that her partner had been violent and drank too much, as had her two previous partners. She said that she was now in a new relationship and for the first time in her life was being treated well.

One piece of information that Mother was keen to share was that she in fact had seven children in total. When asked about the other five she said that she did not have contact with any of them. She did not want to elaborate further on this, except to say their age range and gender. She did also describe some of the incidents that occurred during the review period, such as her partner throwing juice over her eldest child and hitting them on one occasion and shouting at both children frequently.

Mother did say that she felt that she did not receive the support that she needed and when asked what would have helped the family, she said more activities for the children as they were full of energy and difficult to manage. She spoke mainly of "Social Workers" who didn't listen, but did add that she herself wasn't always honest with them. She said she would tell them everything was fine when it wasn't.

The main outcome that Mother wants in respect of her children is that she can see more of them in the future and that they will be able to live nearer her. She thought that this was in progress with respect to her eldest child.

Childrens' views:

A visit was made on **18.01.18** to the children in the therapeutic placement in England in which they reside.

Both children agreed to speak with reviewers, with separate interviews being held and each child contributing equally to the process.

Reviewers met with the youngest child first. when talking about earlier childhood, this child recalled living with Mum and Stepdad, who was described as "not a nice guy", and said that "it was his fault". This child said that Stepdad hit their Mum a lot and hit both siblings. Stepdad's older son was also said to have lived in the house at one point and he was described as a protective factor, as he would stop Stepdad hitting the younger children.

The youngest child also talked positively of a friend's father who "looked after me", vividly describing one particular Hallowe'en being so frightened of Stepdad's rage that they took their toothbrush & toothpaste and bag and ran to the friend's house where they stayed overnight. They also described a time when this father drove both children to somewhere safe. They added that they thought that their friend's Dad told Social Services and/or the Police about Stepdad and that he definitely told Stepdad to stop hurting the children. They also told people about hearing their Mum being hit and crying. The child sounded a little perplexed by this, saying

they thought adults did call the police and told people about Stepdad, but nothing changed and Stepdad remained in the house and continued to hit their Mum and sibling.

The youngest child also said that they told their Mum, but she didn't do anything. They did not however hold any resentment towards their mother for her inaction, consistently talking of her lovingly and repeatedly expressing their desire to return to live with her. There was no understanding of a parental role being to protect children; in fact, they talked of trying to protect their Mum, including threatening Stepdad with knife. They said that they didn't know why their Mum married Stepdad, other than that 'she fell for him' and that they were "glad that he was gone" and that their Mum was now with "a nice man".

The younger child also said they did not tell school staff or their Social Worker what was happening. Whilst they did not fully verbalise their fear of doing so, they did describe feeling very frightened. Their prior perception of nothing changing after they told people may also have impacted on their willingness to risk reporting the abuse from Stepdad.

They also described that their experience of going into care was sudden and unexpected and felt that Stepdad should have gone instead. Their memory of the foster care home was positive, as it had "3D TV and two dogs!" but they didn't understand why they had to leave their home and Stepdad remain.

The oldest child seemed initially more nervous and less chatty than their younger sibling; they twitched and constantly wriggled in their chair. However, they soon relaxed and spoke very articulately. When talking about Stepdad, the older child was unable to say his name, referring to him as "him" or "that man" or on one occasion "Bob". He graphically described Stepdad drinking "lots and lots of alcohol" and becoming "very violent".

The older child was better able to express their lack of trust in adults, saying that at the time it didn't feel safe to tell people and they didn't trust that the adults around them would protect them. They expressed this vey eloquently and emotively as "no one listens to a child-because they are just a child". They also said that since being in the placement they had done life story work where they had been told that Stepdad misses them and loved them, which they saw as further evidence that adults believed adults and not children. When asked specifically the older child said that if they had known that the outcome of disclosing would definitely result in Stepdad being sent away, they would have disclosed earlier.

They did recall how they wanted to tell teachers at school about Stepdad and on one occasion plucked up the courage to do so, but there was a problem with the fire alarm and everyone was distracted and so the moment was lost.

As with their younger sibling, the older child expressed a desire to return to live with their Mum now she was with "someone nice". They saw her as the victim of Stepdad's drinking and violence and did not appear to apportion any blame or express any anger towards her for not protecting the children. They also seemingly accepted Mum's choice of Stepdad as "she fell for him".

Observations re both children:

- Neither child mentioned sexual abuse. The younger one talked purely of physical abuse and used language associated with violence. The older child talked of "the horrible things he did" and "all the terrible things he did to us" but did not elaborate.

Neither child could identify anything else agencies could have done or could have done differently, other than give Stepdad two warnings then "kick him out". They both made reference to the house belonging to Stepdad. The youngest child felt that the decision to place them in care had been both right and wrong.

Recommendations:

- **Consideration to be given by C&V RSCB to effective means of communication with families regarding CPRs. The development of family and child friendly leaflets would be an appropriate task for the RSCB Communication & Engagement Subgroup.**

- **When children make a disclosure and criminal proceedings do not progress then police should explain why further action had not been taken, that their disclosure had been important and that they should continue to make them if new events happen or continue.**

Effective Practice:

Examples of this were identified as follows:

- School referrals to Social Services
- Positive development of MASH
- Level of support offered to family at certain stages
- Foster Carer-positive impact on children-enabling them to feel safe enough to make disclosures and that they would be believed. Able to share what had happened to them and their own thoughts and feelings.
- Police creating and writing policy and procedure for a bespoke way of encouraging children to disclose

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the RSCB and its member agencies and anticipated improvement outcomes:-

Since the period under review there have been a number of local policy and practice changes that have impacted on all agencies involved in child safeguarding.

- Launch of the Multi Agency Safeguarding Hub in Cardiff, **July 2016**, delivering the co-location of statutory agencies using a common platform for sharing information, risk assessments and decision making.
- Introduction of the Public Law Outline (PLO) to ensure decisions about permanency for children are taken within the child's timeframe.
- Introduction of weekly case planning meetings with Senior Managers and Legal Adviser for Children's Services enabling social workers to obtain prompt legal advice
- Implementation of the Signs of Safety model of social work which puts the voice of the child at the centre of the child protection process.
- Mandatory Signs of Safety training for all children's services staff incorporating promoting the voice of the child in assessments and plans.
- Provision of a range of direct work skills training for children's services staff including younger children and teenagers
- Close monitoring of the child protection register to ensure that where a child is subject to a CP plan for 12 months, involvement is escalated.
- Work undertaken by RSCB Audit sub group to review decision-making processes in respect of children named on the Child Protection Register and de-registered within twelve months and children re-registered within twelve months of de-registration
- Children's Services have adopted the use of safety plans, created in conjunction with children and their families, rather than written agreements, which are no longer in routine use.
- 2018-19 training plan includes training on dealing with child sexual abuse
- Restructuring of Children's Services and investment in new teams.
- Children's Services no longer use written agreements except in exceptional and emergency situations. Safety planning now takes place with families who set their own goals for change.
- Operation Encompass to share the PPN's with schools prior to the start of the school day was implemented in September 2018.

Recommendations:

- **Children must be treated as individuals regardless of any shared environments and/or caregivers. Their needs should be assessed and views considered separately. Consideration also should be given to their behaviour, impact on each other and possible risks posed to each other.**

- **In addition to listening to a child's expressed wishes and feelings, professionals should give equal consideration to a child's behaviour and presentation and seek to understand this non-verbal communication.**

- **C&V RSCB should ensure access to multi agency training on the voice of the child with a focus on effective communication methods with younger children.**

- **C&V SCB should ensure training is provided to equip professionals to be able to recognise when a parent has additional needs which mean they require more support to understand the concerns of professionals and what is being asked of them and how to adapt practice accordingly, for example through the use of PAMs assessments.**
- **Professionals must be cautious of placing expectations on vulnerable parents to understand concerns and make the necessary changes within a child's timeframe and must be clear when they do not have the capacity to do so.**
- **When working with families, professionals must take into account family history. Assessments should include any previous experience as a parent and outcomes for any other children, together with an assessment of current parenting capacity and functioning ability.**

- **Decisions must be made within a child's timeframe.**

- **C&V RSCB should ensure all staff are trained to understand that where there a concerns for the safeguarding of children under the age of 18 years, they must share information with colleagues in other agencies, in particular with Police and Children's Services.**

- **C&V RSCB should ensure that all agencies are clear that any Child Protection concerns must be submitted on a Multi-Agency Referral Form (MARF) and within the timescales set out in the All Wales Child Protection Procedures**

- **Police Protection Notices (PPNs) from South Wales Police should be sent to schools in Cardiff as practiced in the Vale of Glamorgan.**

- **All professionals involved should attend Care and Support Planning Meetings and send a representative if they cannot attend.**

- **C&V RSCB to promote the Resolution of Professional Differences Protocol across all agencies. This document should be referenced at Multi Agency Meetings Case Conferences and related meetings and used effectively to facilitate an environment in which it is safe to raise legitimate professional challenge.**

- **Greater understanding is needed with respect to the place of medical evidence and criminal proceedings in cases of alleged sexual abuse to ensure that a direct and damaging correlation is not made between inconclusive findings and outcomes and proof of abuse.**

- **Significant and substantial recognition should be given to a child's presentation and behaviour irrespective of medical evidence and criminal proceedings.**

- **Children who make disclosures should be made aware by police and others that the lack of a conviction does not mean that they are not believed by professionals.**

- **C&V RSCB should ensure access to multi agency training regarding effective ways to communicate with children where sexual abuse is suspected.**

- **C&V RSCB to ensure promotion of the Sexually Harmful behaviour Protocol across all agencies and promote its use in relevant cases**

- **Professionals need to be alert to the possibility that a focus on a medical diagnosis as the explanation for behaviour exhibited by a child presents significant risks of the diagnosis being interpreted as the root cause of all subsequent concerning behaviour displayed by the child.**

- **The term DNA to be replaced with the more accurate "was not brought" in respect of appointments for children. Non-attendance at an appointment should not result in automatic discharge but should be communicated to relevant professionals involved.**

- **All agencies need to have a clear understanding of the processes to be followed when sharing safeguarding and CP concerns as laid out within the AWCPP and referrers and recipients to understand and accept communication as a two-way process, taking responsibility with respect to timely responses and actions.**

- **Multi Agency Training should be provided with regard to referral, reporting and monitoring processes.**

- **For children subject to Child in Need Plans, C&V RSCB should ensure that there are multi agency processes in place to ensure engagement in meetings and plans from all involved with a family; such multi agency contribution is particularly important when decisions re any reduction in support or case closure are being made so that the implications can be fully considered**

- **Where agencies are unable to attend meetings or reviews, they should send a representative.**

- **Clarity is needed with respect to trigger points for legal proceedings to be instigated, particularly where de-registration and re-registration occurs repeatedly.**

- **De-registration must be better understood by all professionals as the removal of a name from the CP Register, but not that the support needs of the children involved have all been met nor that there is no longer need for a co-ordinated professional support network. Care and Support processes need to be robustly co-ordinated and supported by all agencies involved.**

- **Consideration around the use of written agreements as evidenced in this case to be replaced by more open, transparent and supportive approaches which engage and involve the family throughout.**

- **Consideration to be given by C&V RSCB to effective means of communication with families regarding CPRs. The development of family and child friendly leaflets would be an appropriate task for the RSCB Communication & Engagement Subgroup.**

- **When children make a disclosure and criminal proceedings do not progress then police should explain why further action had not been taken, that their disclosure had been important and that they should continue to make them if new events happen or continue.**

Statement by Reviewer			
Reviewer 1		**Reviewer 2** (as appropriate)	
Statement of independence from the case Quality Assurance statement of qualification		**Statement of independence from the case** Quality Assurance statement of qualification	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case. • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.	
Reviewer 1 (signature)		**Reviewer 2** (Signature)	
Name (Print)		**Name** (Print)	
Date		**Date**	
Chair of Review Panel: **Signature:** …….. **Name** (print):……..			

Date:……

Documents added as appendix
Appendix 1: Terms of Reference ☐
Appendix 2: Summary Timeline ☐

Child Practice Review Process

To include here in brief:

- The process followed by the RSCB and the services represented on the Review Panel.
- A Learning event was held and the services that attended.
- Family members' had been informed, their views sought and represented throughout the learning event and feedback has been provided to them.

Cardiff and Vale RSCB notified Welsh Government that it was commissioning a Child Practice Review in respect of Case CPR 01/2014 in February 2014. The reasons for the significant delays in the process and completion of the report are outlined in the TOR (**Appendix 1)**

The Review Panel (2017): The panel met between **February** and **November 2017** to review the process and multi-agency timeline, providing analysis and supporting development of the report

Reviewers: **Jackie Vining**
Assistant Director Children's Services
Barnardo's Cymru

Debbie Cyrille
Independent Reviewer (from February to August 2017)

Gill Toon (From Sept 2017)
Complex Needs Manager / Principal Educational Psychologist ,
School Improvement & Inclusion, Vale of Glamorgan

Chair: **Dorian Davies**
Vale of Glamorgan Education

The following agencies were represented on the Panel :

- South Wales Police
- Wales Ambulance Service

- CAFCASS
- Cardiff Education Services
- Cardiff and Vale University Health Board
- Taff Housing Association
- Cardiff Housing
- NSPCC
- Cardiff Women's Aid
- (Cardiff Children's Services?)

Learning Event:
Professionals from across all agencies who had been directly involved with the family during the period of the agreed timeline were invited to a Learning Event that took place on **Wednesday 13.09.17** in Civic Offices in Barry, Vale of Glamorgan. The event was attended by representatives from the following agencies:

Panel Chair: Dorian Davies **Reviewers:** Jackie Vining & Gill Toon

Cardiff Children's Services x 4
Cardiff Women's Aid x 2
Cardiff Education Services x 3
South Wales Police x 5
South Wales Ambulance Service x 2
LAC Nurse
School Nurse
Community Paediatrician ,Child Health Team
Independent Domestic Violence Advocate

Apologies were received from 4 representatives from:

- Cardiff Children's Services (IRO)
- Taff Housing
- CAFCASS
- Cardiff Education Services (but were represented by 3 attendees)

Staff from the C&V RSCB Business Unit supported the facilitation of the Learning Event.

☐ **Family Declined involvement**

For Welsh Government Use Only

Date information received:

Date acknowledgement letter sent to RSCB Chair:

Date circulated to relevant inspectorate /Policy Leads:

Agencies	Yes	No	Reason
CSSIW			
Estyn			
HIW			
HMI Constabulary			
HMI Probation			